Phelps M.D.
INTEGRATIVE MEDICINE

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Women's Intake Form

If you are uncomfortable answering any questions, please leave them blank

Menarche Date (first period started)_____LMP_____

Cycle Regularity (Where on the scale below?)

1_____5_____ 10
Always irreg sometimes irreg rarely irreg Always Reg

Cycle Length_____ Periods last how long?_____
If irregular, what is range (shortest cycle length to longest cycle length)

Cycle Symptoms

Breast tenderness? When in cycle?_____
_____

Bloating? When in cycle?_____
_____

Skin breakout? When in cycle?_____
_____

Weight gain? When in cycle?_____
_____

Mid-cycle pain?_____
_____

Food cravings? What foods? When in cycle?_____
_____

Spotting?
When?_____
_____

Cramping?
When?_____
_____

Menstrual symptoms?

Number of days of bleeding?_____
_____

Heavy periods?
#pads/tampons/day_____
_____

Cramping? Where? When? How long?_____
_____

Breast History

Do you have a family history of Breast cancer? Please give details of who in family and if they are still alive and any details of their cancer that you are aware of?_____
_____
_____

Do you perform self breast exams? How often?_____
_____

Have you ever had a breast lump?_____
_____

Have you ever had a breast biopsy?
_____
_____

Have you had any breast surgery? If so, when?_____
_____

Have you had a mammogram? When was the last one?_____

Have you had an abnormal mammogram? Give details_____

Maternity History

Are you pregnant now?_____
If yes, when are you due?_____
children , age/birthdate(s)

_____

_____

Are all your children alive? _____
For each child, vaginal or C-section/complications at birth?

_____

_____

#Miscarriages, How far along for each?

_____

Elective abortions? Premature birth?
Stillbirth?_____
Do you want to become pregnant in next two years? _____
Do you take prenatal vitamins with folic acid? _____
Are you using any kind of birth control? If yes, what kind? What have you used in the past?

_____

_____

Do you know about morning after pill? _____
Depression before/after pregnancy?_____
Have you been treated for infertility?_____
Have you adopted any children?_____

Pelvic history

Have you ever had a pelvic exam? _____
When is the last time you had a pap smear? _____
Have you ever had an abnormal pap smear? If so when? Current status?

_____

Do you ever use a douche? How often? What kind?

_____

Are you sexually active? _____
If yes, how often? _____
Have you had multiple partners? If yes, approx how many? _____
Partners Male?_____Female?_____ both?_____
Do you have pain with intercourse?_____
How is your sexual appetite? _____
Do you have any history of yeast infections?_____
Have you ever been treated for an infection/herpes/venereal warts? If yes, give details and dates

_____

_____

Menopause

Have you had a hysterectomy? If so, when?_____
Are you still having periods? If not, when did they stop? _____
Have they changed?
How?_____
Has your cycle length changed? _____
Have your menstrual symptoms changed? _____
Do you have hot flashes? If so how many/day? _____
Has your sleep changed? If so, how? _____
Do you know your mother's menopause history? _____
Has your metabolism changed? What do you notice as different?
_____
Have your moods changed? How?
_____
_____
Do you have vaginal dryness? _____

Bone Density History

- Do you have a lack of energy? * Yes No
- Do you feel stressed? * Yes No
- Do you experience restless sleep or insomnia? * Yes No
- Do you feel sad and/or grumpy? * Yes No
- Do you have mood swings? * Yes No
- Do you have difficulty concentrating? * Yes No
- Are you forgetful? * Yes No
- Do you have premenstrual symptoms? * Yes No
- Do you have pre- or postmenopausal hot flashes and/or night sweats? * Yes No
- Have you noticed a decrease in your sex drive? * Yes No
- Have you recently gained weight? * Yes No
- Are you overweight? * Yes No
- Have you lost height? * Yes No